

North Carolina Department of Health and Human Services
Division of Medical Assistance
Topical Anti-Inflammatory Medications PA Request Form

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Recipient Gender: _____

Prescriber Information

6. Prescribing Provider NPI#: _____
7. Requester Contact Information Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Med requested: ___ Elidel ___ Eucrisa ___ Protopic 0.03% ___ Protopic 0.1%
 ___ tacrolimus 0.03% (generic) ___ tacrolimus 0.1% (generic)
 ___ pimecrolimus (generic)
9. Quantity per 30 days _____ 9a. Duration _____

For Coverage of Elidel and Eucrisa

1. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 2 years of age? ___ YES ___ NO
2. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 2 years of age? ___ YES ___ NO
3. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___ YES ___ NO Please List: _____

For Coverage of Protopic 0.03%, tacrolimus 0.03% (generic), and pimecrolimus (generic)

4. Has the recipient tried and failed Elidel or Eucrisa? ___ YES ___ NO
5. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 2 years of age? ___ YES ___ NO
6. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 2 years of age? ___ YES ___ NO
7. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___ YES ___ NO Please List: _____

For Coverage of Protopic 0.1%, and tacrolimus 0.1% (generic)

8. Has the recipient tried and failed Elidel or Eucrisa? ___ YES ___ NO
9. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 18 years of age? ___ YES ___ NO
10. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 18 years of age? ___ YES ___ NO
11. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___ YES ___ NO Please List: _____

Signature of Prescriber: _____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

DMA-3459